Screening and Brief Intervention for Drug Use: Resource Guide

Editor
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FOREWORD

WHO estimates provided in the Global Burden of Disease indicate that tobacco, alcohol and illicit drug use, singly or in combination, are among the top 20 risk factors for ill-health. It is estimated that alcohol is responsible for 3.8% of deaths and 4.5% of Disability Adjusted Life Years (DALYs) in the population worldwide. Similarly, illicit drugs are responsible for 0.4% of deaths and 0.9% of DALYs in the world.

The traditional approach to reduce the use of alcohol and illicit drugs has been through the provision of drug dependence treatment services through various specialist centres. However, it is seen that only the patients whose problems become acute present themselves to these centres. Further, access to the specialist centres is limited as they are few in number and located mostly in the metropolitan centres. Individuals who have problematic alcohol or drug use but are still early in the course of illness, remain in the primary health care setting, where they come for treatment for other illnesses.

It is, therefore, important for primary health care workers who are uniquely placed in treatment of such individuals, to be able to identify such cases and intervene at an early stage in the progressive cycle of substance use. To address the growing problem imposed by alcohol and illicit drug use, the World Health Organization has advocated the use of Brief Interventions, which can be easily delivered by a range of health professionals, from physicians and nurses in a busy medical setting to community based health workers. These interventions can assist the primary health care workers in conducting simple but effective interventions for subjects whose substance use is exposing them to health risk. This manual entitled "*Screening and Brief Intervention for Drug Use: Resource Guide*", developed by the National Drug Dependence Treatment Centre, provides a comprehensive coverage and practical guidance on use of brief interventions for hazardous and harmful substance use in primary care setting.

I wish to congratulate the team of professionals at the National Drug Dependence Treatment Centre, for their efforts in developing this manual. It will certainly help to train and empower the primary care professionals in screening for hazardous substance use and delivering Brief Interventions. Publishing of this manual is a welcome development and it will go a long way in meeting the challenges of substance use disorders in India.

PREFACE

Not everyone who uses alcohol or any other psychoactive substance can be classified as a dependent user, but one doesn't have to become dependent on psychoactive substances to experience complications related to their use. Among the various substances of abuse, tobacco and alcohol occupy a very special place . By the dint force of their sheer numbers, they carve a separate niche for themselves . The substance use management professionals have all along been very comfortable in dealing with individuals who were defined as "alcoholics" or drug addicts and are now called 'substance dependent patients' and there is abundant litreture on with modalities to handle them.

However the group of users of alcohol and other psychotropic substance who drink/use it excessively and have been classified hazardous and harmful users is much larger. The most widely used strategy to manage this category of cases is the wide range of interventions collectively referred to as Brief Interventio. The main attraction of this lies in the simplicity, efficacy , feasibality and costeffectiveness. These interventions are meant to be carried out not just by physicans but a wide variety of of medical and para professionals therby increasing the utility and the reach of the intervention.

This manual titled 'Screening and Brief Intervention for Drug Use: Resource Guide', provides useful information about concepts and terminologies of drug use , process of screening for drug use and providing brief intervention to patients who are facing problems or are at risk of developing problems due to their substance use . It offers strategies to motivate patients to change their risky substance use pattern and offers a step by step approach to deliver brief intervention to harmful and hazardous substance users.

The appendices contain information sheets for educating patients about potential harms associated with substance use and useful tools to screen for alcohol and substance use inside

Rakesh Lal

ACKNOWLEDGEMENTS

This manual was developed due to a constant feedback that paramedical personnel are capable and need to be involved in the management of drug abuse disorder. Their involvement has been particularly mooted for patients who are not yet dependent but are using drugs excessively and exposing themselves and society to harm.

I would like to express my sincere gratitude to Professor Rajat Ray, Head , Department of psychiatry and Chief, National Drug Dependence Treatment Centre , All India Institute of Medical sciences, for inspiring me to work in the field of brief intervention and permiting me to develop this manual.

I would like to thank the Ministry of Finance , Department of Revenue for appreciating the need for this manual ,and making available funds from NFCDA to publish this guide.

The contributors for this manual include social service officers, psychologists, who have addressed the issue of brief intervention from different perspectives and given a wholesome look to the final product

Rakesh Lal

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1

About This Manual

This manual aims to make the reader aware of various psychoactive drugs that have an abuse potential and familiarize them with concepts, definitions and terminologies used in the field of drug abuse management.

This resource guide in intended to be for use by psychiatrists, doctors from other fields of specialization , general physicians, nurses,and social welfare professionals . Combined with a training program, the guide can be used as a resourse material for for management of harmful /hazardous users of alcohol and other psychotropic substance.

The reader of the manual is expected to be comfortable with screening for drug use and be in a position to identify and conduct brief intervention for those individuals for whom it is beneficial.This manual is being developed as a resource material for these training courses.

Since, substance abuse is a growing concern among patients in primary health care settings, it is important to screen for drug use to make patients aware of the risks associated with their current drug use patterns, Additionally, since patients with moderate risk may be reluctant to go to specialist settings, delivering brief intervention in a primary health care setting may help to address issues pertaining to the user's drug use in a relatively short time , in a cost effective manner and in an acceptable enviornment.

Together with the information sheet, this manual presents a comprehensive and practical approach to screening and brief intervention which is tailored to the primary health care setting. If brief intervention strategies as described in this manual are employed they can result in improved mental and physical health and quality of life among the patients attending primary health care services.

This manual describes:

1. The definitions and concepts associated with substance use and the rationale for screening and intervention at the Primary care setting.

2. The principles and skills for motivational interviewing and models for behavior change.

3. The process of screening to ascertain the patterns of substance use and decide the mode of intervention.

4. The concepts of brief intervention and the process of conducting a brief intervention session for moderate risk users.

5. Practical session to describe how to conduct screening and brief intervention.

2

Drug use: Concepts and Definition

Drugs

A drug is any chemical which when absorbed into the body of a living organism, alters normal bodily functions. Correspondingly, a psychoactive drug or a substance is any chemical that, upon consumption, leads to changes in the functioning of human mind and more specifically leads to a state of intoxication. Examples of substances are alcoholic beverages, opioids , cannabis and tobacco products (cigarettes, chewable tobacco),.

A person may take drugs due to various reasons but the main reasons can be either or all of 3Fs:

- Fun or pleasure
- Forget or reduce pain
- Functional – for certain purposes like to be a better conversationalist in a social gathering, or to ehnace physical performance .

Psychoactive substances alter the user's mood, cognition and behavior. e.g , when a person consumes alcohol , he may feel happy (change in mood), have difficulty in concentrating (cognition) and may have an unsteady gait or slurred speech (behavior).

Types of Drugs

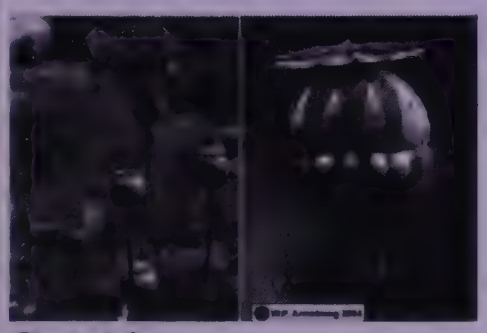
Classification of drugs helps in understanding and approximating their effects, possible harms and potential withdrawal features. Drugs may be classified as per their status or action and properties. Classification based on status includes:

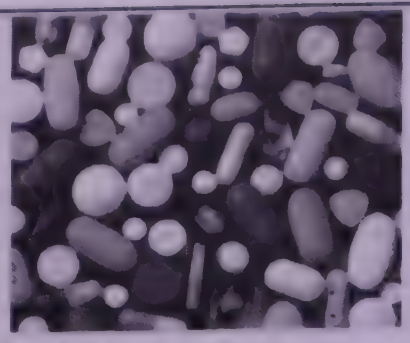
- Legal Status – legal sanctions may apply to psychoactive drugs for their manufacture, possession, supply and use; substances like alcoholic beverages and Nicotine (Tobacco), are legally allowed for trade and consumption in most states of India (albeit with some regulations). These are called **Licit** (or Legal) substances. The trade and consumption of many other substances like cannabis and opioids are strictly prohibited and are therefore they are called **Illicit** (or Illegal) substances.
- Medical applications – example, opioids used for pain alleviation (morphine, diamorphine)
- Classification Based on action and properties :

Depressants	Stimulants	Hallucinogens
• Alcohol	• Cocaine	• LSD
• Opioids	• Amphetamine Type Stimulants	• Cannabis
• Sedative – hypnotics	• Tobacco	• Ketamine, Dextromethorphan
• Volatile solvents	• Caffeine	• Other (e.g., N_2O, nutmeg/mace)
• Cannabis	• Betel	• Khat

Some of the substances and their street names are given below in Table 2.

Table 2: Street names of commonly used substances in India

Commonly used substances in India	Street Names
 Alcohol	Whisky, Rum , Brandy, Gin, Vodka, Wine, Beer, Breezer, Tharra, Sura, Arrak, Tadi,
 Opioids	Smack, Brown sugar, Pudia, gard, samaan, Tidigesic, Norphine, Pentazocine, Morphine Afeem, Powder, Bhukki, Post, dodda , Maal Proxyvon, Spasmo proxyvon
 Cannabis	Bhang, Charas , Ganja

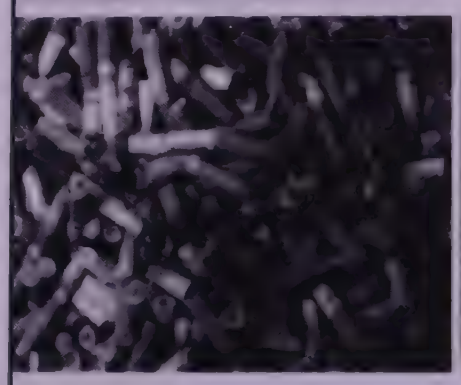


Sedative – hypnotics

Diazepam (Valium), Nitrazepam (Nitravet), Alprazolam (Alprax)

Volatile solvents

Fluid, white fluid, solution, Iodex, petrol,



Tobacco

Bidi, Cigarette , Hukka, Gutka, Zard, Kaini, Surti, Gul, Naswar, Dentopak

Alcohol, Tobacco and Cannabis are the most frequently used substances in the Indian context.

Alcoholic beverages are available in various forms. These include distilled spirits or IMFL (Indian Made Foreign Liquors), beer and wine. Distilled spirits such as whisky, brandy, rum, vodka and gin contain about 42% alcohol , whereas beer usually contains 4 to 8%, and wines contain approximately 12% substance. Due to these variations, alcoholic drinks are measured in standard units. One standard unit (drink) of a Alcohol constitutes 10ml of the absolute Alcohol . The rule of thumb for comparison is provided in the illustration (Fig : 1) .

Figure 1 : standard drink

Tobacco products are available in numerous forms such as cigarettes, bidi and smokeless tobacco such as gutkha.

Cannabis is available in various forms.

Bhang- paste of leaves of the plant or dried leaves,

Ganja – dried flowering stem of the plant and

Charas or hashish – extracted from the resin covering the plant. It can be smoked in cigarettes, or in clay pipes (most common method in religious settings and rural areas) or in water pipes like the traditional hookah.

Bhang, which is used in various religious festivals, is legal in India. *Charas* and *Ganja* which are also obtained from the same cannabis plant are illegal.

How much is too much?

Men may be at risk for alcohol related problems if their alcohol consumption exceeds 14 standard drinks per week or 4 drinks per day, and women may be at risk if they have more than 7 standard drinks per week or 3 drinks per day

Source: National Institute on Alcohol Abuse and Alcoholism. Helping Patients Who Drink Too Much:

A Clinician's Guide. NIH Publication No. 05-3769

Important concepts / definitions

To gain a comprehensive understanding of substance use, it is important to become acquainted with the important terminologies and definitions, which are presented in table 3.

Table 3: Important terminologies and definitions used in the context of substance abuse

Terms	Definition/Explanation	Illustrative Examples
Use	• Consuming a psychoactive substance without experiencing any negative consequences. • Social/recreational/experimental use • Dietary practice/religious ritual	A student smokes a cigarette of charas at a party and his parents did not fined out
Misuse	• On consuming substance, the person experiences negative consequences	A person drinks excessively at a party, and while driving back to home gets arrested for drunken driving
Abuse	• Continued use with negative consequences such as those resulting in physical, social or legal harm	A person continues to drink alcohol after repeatedly having accidents while operating heavy machinery

Harmful use	• Pattern of substance use or consuming drugs which is already causing damage to health	A person suffers from liver damage due to chronic substance use
Dependence (ICD-10, WHO 1992	Cluster of physiological, behavioral and cognitive phenomena in which the use of a substance or class of substances takes on a higher priority for a person as compared to other behaviors that had great value Dependence is characterized by three or more main symptoms: • *Tolerance* (need to enahce quantitity of intake to get the same effect) • *Physiological withdrawal state* (physical and psychological discomfort on missing the dose) • *"Loss of control"* (substance being often taken in larger amounts or over a longer period than intended); or a persistent desire or unsuccessful efforts to re-duce or control substance use.· • *Preoccupation with substance use*, important alternative pleasures or interests being given up or reduced; or a great deal of time spent in procuring, taking or recovering from the effects of the substance. • *Continued use in spite of clear evidence of harmful consequences*· • *Strong desire to use substance (craving)*	A person continuously using substance and is not able to control his substance use. When not able to drink he has symptoms like tremors of hands, nausea, sweating, etc.

Prevalance of substances use in India

Tobacco, alcohol , cannabis, opium and heroin are the major drugs of abuse in the country.

The National Household Survey of Drug Use and National Family Health Survey in the country are the systematic effort to document the nation-wide prevalence of drug use [Table 4]. As per NHS survey 2000-2001 Alcohol (21.4%) was the primary substance used (apart from tobacco) followed by cannabis (3.0%) and opioids (0.7%)

Nationwide studies on substance use prevalence		
	Survey /year	**Prevalence**
1	National household survey (NHS) 2000-2001	Tobacco_55.8% (amongmales) Alcohol - 21.4% Cannabis - 3% Opiate - 7%
2	National Family health survey (NFHS 3), 2005-2006	Tobacco : 57% men and 11% women Alcohol :31.9% for men and 2% for women Tobbaco Use : 57% for men and 11% for women

Table 4: prevelance of commonly used substances in India

Estimated size of Current users (NHS 21000-2001)		
Alcohol-62.5 million	Cannabis-8.7 million	Opiates-2.0 million

Table-5

As per NHS 2000-2001 , the estimated size of current alcohol user are 62.5 million, cannabis user 8.7 million and opiate user are 2million . Out of these 17 to 26% are dependent users

Tobacco use prevalence was high at 55.8% among males, with maximum use in the age group 41-50 years. The most recent prevelance assessment through NFHS(3) 2005- 2006 reports use of alchol by 31.9% among men aged 15-54 years and 2% among women aged between 15 to 49 years. The prevelance of tobacco is 57% & 11% for men and women respectively.

It must be remembered that India being a vast country, has a lot of variation in the substance use pattern. However in general, drug abuse is seen in both rural and urban parts of India. Mostly young adult males are affected by substance use, although a small minority of women also indulged in substance use. Unfortunately, many substance users do not seek treatment and those who sought seek treatment reported late allowing the use of substance to advers affect their physical health and social functioning . It is important therefore to screen substance use at the first available opportunity and provide timely and appropriate intervention .

3

Screening And Brief Intervention Primary Health Care setting

Cumulatively Tobacco, alcohol and illicit substance use are responsible for about 10% of the deaths in the world

Screening tests help to sort out persons who probably have a disease or problem from those who do not. Persons with positive findings are usually referred for appropriate treatment. Tobacco, alcohol and illicit drugs constitute top 20 risk factors for ill-health as identified by the World Health Organization. It is estimated that tobacco is solely responsible for 8.7% of total deaths and for 3.7% of the global burden of total number of diseases. , which is measured as the number of years lost due to premature death or disability (Disability Adjusted Life Years – DALYs), while alcohol is responsible for 3.8% of deaths and 4.5% of DALYs. Illicit drugs are responsible for 0.4% of deaths and 0.9% of DALYs.

Hazardous and harmful alcohol use and the use of other substances also pose as risk factors for a wide variety of social, financial, legal and relationship problems for individuals and their families. Globally, there is an increasing trend for people to use multiple substances, either together or at different times, which is likely to further increase the risks. Additionally, for some substances like alcohol and cannabis, dependent users are lesser as compared to harmful and hazardous users but maximum health services cater to dependent users . It is important to know that help seeking even for dependent substance use is very low , as only 18% alcohol dependents and 2% of opiate dependent individuals seek treatment (National Survey on Extent, Patterns and Trends of Drug Abuse (2004) . And those who are harmful or hazodous user help seeking is almost negligible.

2 descibes the pattern of help seeking among various categories of substance users . Help for treatment is often sought by those who have become dependent, and harmful hazardous user do not seek treatment, although their numbers are more and by their sheer number they pose a large burden on public health then dependent users.

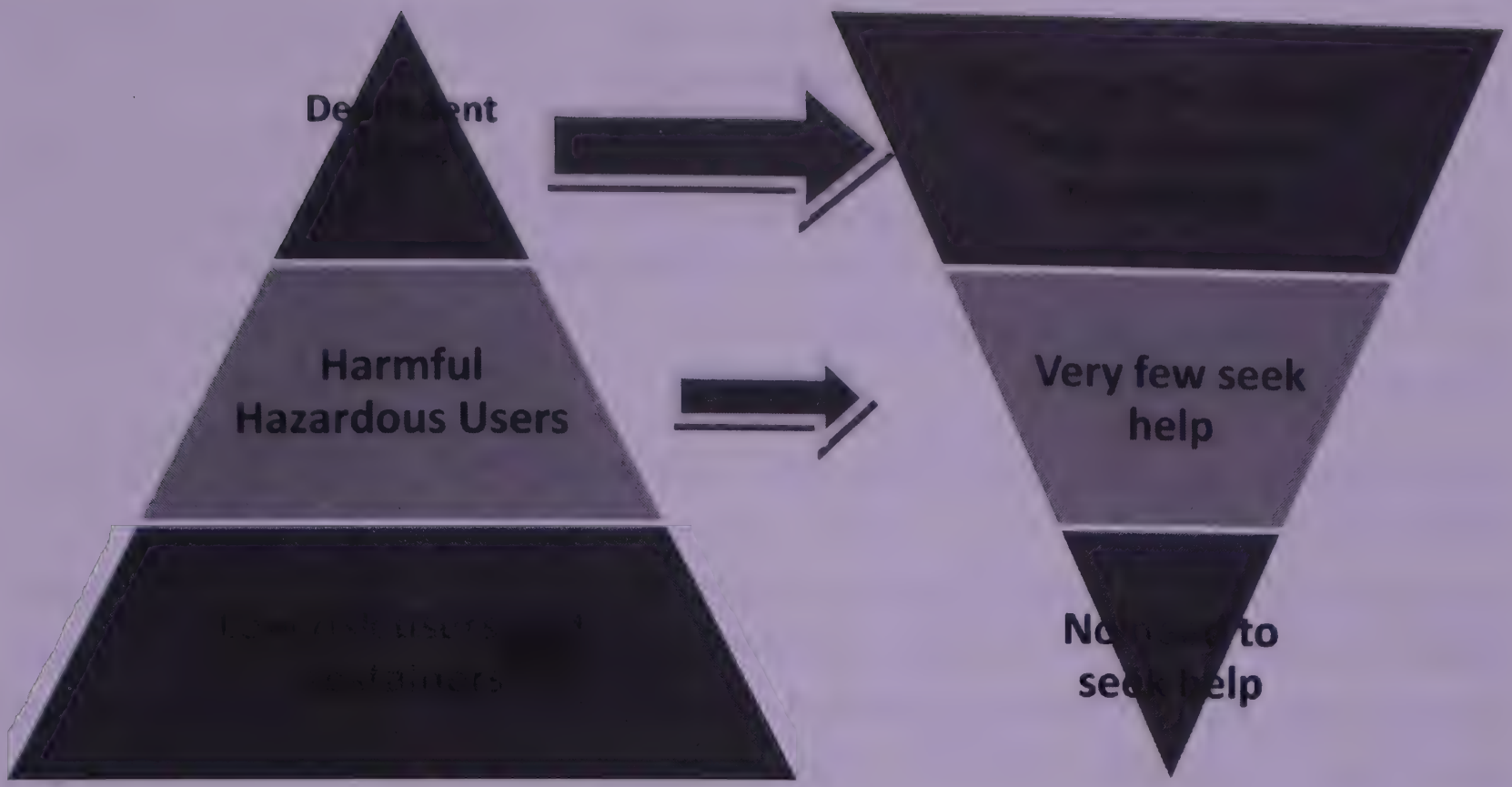


Figure 2: **Pattern of help seeking in substance users**

Brief interventions in substance abuse provide a viable option in the form of cost-effective and time-efficient psycho-social strategies that aim at reduction of substance use and/or harm related to substance use. They are grounded in the scientific principles of harm reduction, stages of change, motivational interviewing and feasibility of community-level delivery.

In the context of psychoactive substance abuse, brief interventions can be defined as a group of strategies which aim at reduction of substance use *(demand reduction)* and/or harm related to substances *(harm minimization)*, in a cost-effective and time-efficient manner, by imparting brief or minimal advice/counseling to the users of alcohol ce, tobacco or other drugs.

Screening and brief interventions aim to identify current or potential problems with substance use and motivate those at risk to change their substance use behavior.

It must be borne in mind that brief interventions are not intended to treat people with Severe substance dependence as they require specialized intervention . But there is robust evidence to suggest that it works very effcitively for harmful and hazardous substance users. Certain studies have compared effectiveness of brief interventions with extended counseling, and found the former to compare quite favorably with the latter, particularly in subjects with mild level of substance dependence. However one must bear in mind the level of drug dependence and associated complication. and should not conclude that brief interventions are as effective as extended counseling for severe dependence.

There is strong evidence for effectiveness of brief interventions in primary care settings for alcohol and tobacco abuse, and growing evidence for effectiveness for abuse of other substances. Research also suggests an effective and feasible role of culturally appropriate brief interventions in primary care settings for alcohol use other than substance. Studies

supporting effective role of brief interventions are available regarding cannabis, benzodiazepines, amphetamines, opiates and cocaine.

India, with a large population size and a widespread primary health care infrastructure, presents a fertile ground for application of these strategies. Primary health care doctors and health care professionals could be sensitized and trained in this direction to initiate the process (through assessment screening and brief intervention) and appropriate referral of patients to treatment agencies.

Rationale for training primary care professionals in delivering brief intervention

Primary health care professionals are in a unique position to identify and intervene with patients whose substance use is hazardous or harmful. Health promotion and disease prevention play an important role in the work of primary care workers, who are often engaged in implementing activities around screening and prevention including immunization, and detection of high blood pressure, obesity, smoking and other risk factors to various illnesses.. Patients view primary care workers as a credible source of advice about health risks including substance use. A significant percent of the population visits a primary health care worker and primary health care setting is most often the first point of contact for individuals who drinks excessively or for tobacco and other substance users . Patients whose substance use is hazardous or harmful are likely to have more frequent consultations. This means that primary care workers have the opportunity to intervene at an early stage before serious substance related problems and dependence develops. Many common health conditions seen in primary care may be related to tobacco or other substance use, and the primary care worker can use this link to introduce screening and brief intervention for substance use. The intervention comprises part of the management of the presenting complaints. Primary care workers often have an ongoing relationship with their patients who enable them to develop rapport and gain an understanding of their patients' needs. Patients generally expect their primary care clinician to be involved

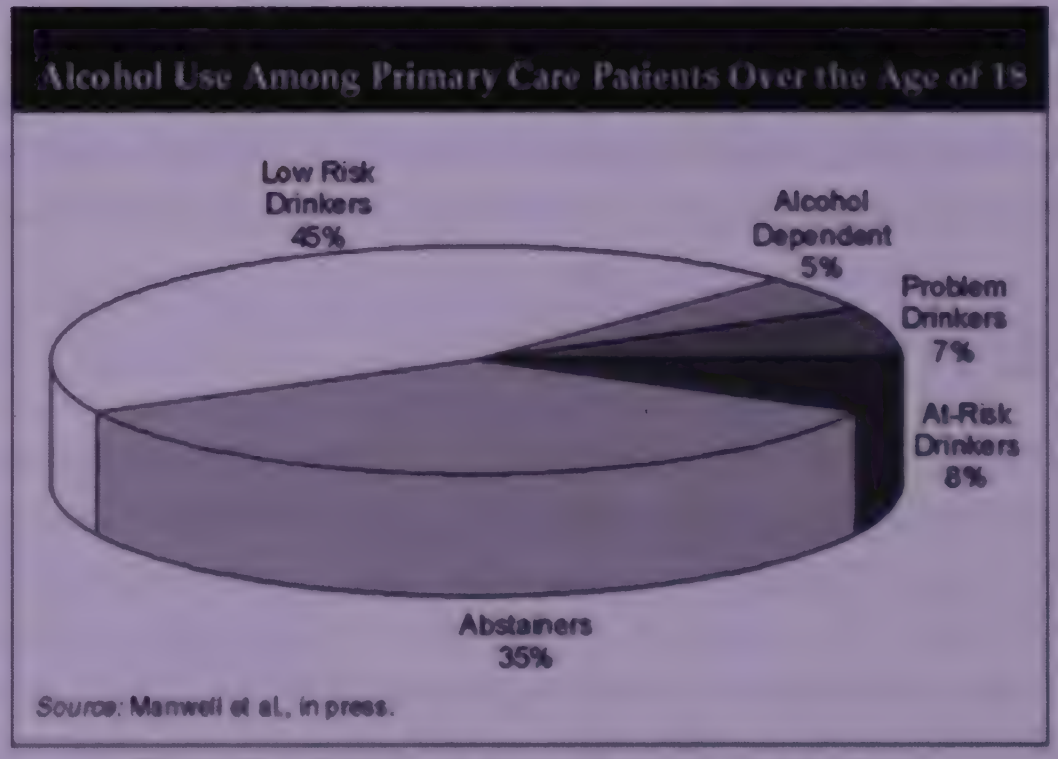


Figure 3 : alcohol use among primary care patients

in all aspects of their health and are likely to feel more comfortable about discussing sensitive

issues such as substance use with someone they know and trust. The ongoing nature of the relationship also means that interventions can be spread out over time and form part of a number of consultations.

Brief interventions can be used opportunistically in a variety of settings for people not in contact with drug abuse management services (for example, in mental health, general health and social care settings, and emergency departments) and for people in limited contact with drug abuse management services (such as at needle and syringe exchanges, and community pharmacies). Primary care physicians and health workers are invariably the first contact for the patients and are in a unique position to identify the problematic substance use. Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

Research for effectiveness of Brief Interventions in Primary Care and other Settings Brief interventions have been found to be increasingly valuable in reducing the harmful or

Why screen and intervene?

The purpose of screening for substance use in primary care settings is to prevent substance related disabilities in persons at risk. Hazardous and harmful use should be prime targets for delivering brief intervention

hazardous substance use patterns among individuals. There is an overwhelmingly strong evidence-base to support using brief intervention techniques in such individuals. Some important studies using brief interventions are summarized in the table below.

Brief Intervention works : There is robust research evidence to conclusively indicate that brief intervention is a an effective stand alone intervention to address the issue of harmful and hazardous substance use. And the attraction to use it more for patients befits lies in the fact that it can be delivered by non specialist, across different settings (hospital as well as general welfare) and is less resource and time intensive.

Table 5: Research Evidence for Brief Intervention

Author and Year	Setting	Method	Outcome
Sullivan et al. (2011)	Primary Care	Meta analysis and systematic review of 13 studies	Brief interventions delivered by non-physician staff in primary health care settings were found to be as useful as physician delivered brief interventions to reduce substance use behavior among patients.
Kaner et al 2009 Cochrane review	General practice (24 trials) and emergency setting (5 trials)	Meta analysis and systematic review of 29 randomised control trial from countries various	The benefits of brief intervention were similar in the normal clinical setting and in research settings with greater resources. Longer counselling had little additional benefit. The benefits of brief intervention were similar in the normal clinical setting and in research settings with greater resources. Longer counselling had little additional benefit.
Stead et al 2008 Cochrane review	smoking cessation	meta-analysis incorporating 28 trials and over 20,000 participants,	A brief advice intervention is likely to increase the quit rate.
Kaner et al. (2007)	Primary Care	Meta-analysis of 22 RCTs (enrolling 7,619 participants) was conducted	Overall, brief interventions lowered alcohol consumption. When data were available by gender, the effect was clear in men at one year of follow up, but not in women. Longer duration of counseling probably has little additional effect.
Bertholet et al. (2005)	Primary Care	Systematic review of 17 studies	8 studies showed an overall beneficial reduction in alcohol use, which was sustained over a 6-12 month period.
Pal et al (2004)	Community , Hospital	RCT BI Vs simple advice	Brief intervention works better than simple advice in terms of changing motivation, reduction in substance use and enhancing QOL
Pal et al. (2002)	Community , Hospital	RCT	Quantity and frequency of alcohol and cannabis decreased significantly

4

SCREENING

Substance abuse screening is to identify individuals who have developed or are at risk for developing substance- or drug-related problems, and within that group, to identify patients who need further assessment to diagnose their substance use disorders and formulate a plan for intervention . Screening is conducted systematically using standardized and validated instruments.

Screening Tools for Substance Use

The following table briefly describes the characteristics of some of the tools that are widely used and have been validated in various settings and with general and specialized populations. Some of these tools are designed to detect substanceism, while others detect risky substance use or harmful substance use.

Table 6: Description of screening tests for substance use

TEST	DESCRIPTION
ASSIST (Alcohol Smoking and Substance Involvement Screening Test) Appendix- 1	• This test was developed by World Health Organization • It constitutes of 8 items • The test is self administered or administered in interview format • The purpose of the test is to identify low, moderate and high risk substance use like such as tobacco, alcohol , cannabis, cocaine, amphetamine type stimulants, sedatives, hallucinogens, inhalants, opioids and other drugs • It is cross culturally valid
AUDIT (Alcohol Use Disorder Identification Test) Appendix-2	• This test was developed by World Health Organization • It constitutes of 10 questions • The test is self administered or administered in interview format • The purpose of this test is to identify harmful alcohol use • It has cross-cultural validity
CAGE Cut down, Annoyed, Guilty, Eye-Opener Appendix -3	• CAGE is an acronym for the questions • It has 4 questions • It is administered as a clinical interview • The purpose of the test is to detect alcoholism • No cutoff score is provided to differentiate dependence from abuse

CRAFFT Car, Relax, Alone, Friends, Forget, Trouble Appendix - 4	• CRAFFT is an acronym for questions 6 questions • It is administered as a clinical interview • It is designed for adolescents • The purpose of the test is to identify high risk use warranting further evaluation
DAST (Drug Abuse Screening Test) Appendix-5	• It constitutes of 28 questions • It may be self-administrated or administered as an interview • The purpose of this test is to detect drug problems
Fagerstrom Nicotine Dependence Test Appendix -6 **MAST** Michigan Alcohol Screening Test Appendix-7	• It constitutes of 5 questions • It is administered as a clinical interview • This tests helps to assess the level of nicotine dependence • It constitutes of 25 questions • It may be self-administered or administered as an interview • It helps to detect alcoholism

The current manual recommends use of either AUDIT or ASSIST, developed by the World Health Organization as both of these test are cross culturally valid, available in Hindi and are highly sensitive. A brief description of these screening instruments is as follows:

AUDIT: The AUDIT constitutes of 10 questions and is intended to identify persons with hazardous and harmful alcohol use. The first three items measure the frequency and quantity of regular and occasional alcohol use of the person. The next three assess the occurrence of possible dependence symptoms, while the last four items probe about the recent as well as lifetime problems that are associated with alcohol use.

ASSIST: The ASSIST consists of 8 items, which cover information pertaining to the substances individuals have ever used in a lifetime, the substances individuals have used in the past 3 months, problems related to substance use, risk of current or future harm, dependence and injecting drug use. As opposed to the AUDIT, which is geared to identify only alcohol use problems, this instrument helps to identify individuals with harmful or hazardous use across a wide range of psychoactive substances such as tobacco, alcohol, cannabis, cocaine, amphetamine type stimulants, sedatives, hallucinogens, inhalants, opioids and other drugs.

The level of risk determined by the scores of the AUDIT or ASSIST help the healthcare professional decide the mode of intervention to be delivered. Below is a table of the score ranges and corresponding risk levels.

Table 7: Scores on screening tests and corresponding risk level and intervention

Score	Risk level	Intervention
ASSIST - 0 – 10 (Alcohol) ASSIST – 0-3 (Other substances) AUDIT – 0-15	**Low**	• Simple advice about the possible harms. • Give information sheet
ASSIST - 11 – 26 (Alcohol) ASSIST – 4 – 26 (Other substances) AUDIT – 16-19	**Moderate risk / Hazardous alcohol use**	• Brief intervention • Give information sheet
ASSIST – 27+ (Alcohol & Other Substances) AUDIT - 20-40	**High risk/ dependence**	• Brief intervention • Give information sheet • Referral to specialist

There are several important **steps** to take before you start providing Screening and Brief Intervention. They include:

- Choosing a screening tool as per the requirement.
- Clarifying logistics of the setting(s) in which you will be conducting screening, including making sure that systems for maintaining privacy and confidentiality are in place.
- Compiling a current list of organizations and providers for referrals to services
- Practicing screening.
- Inform the patient that screening is a vital component of a brief intervention.

A typical process of Screening and brief intervention is described below in the flow chart illustration

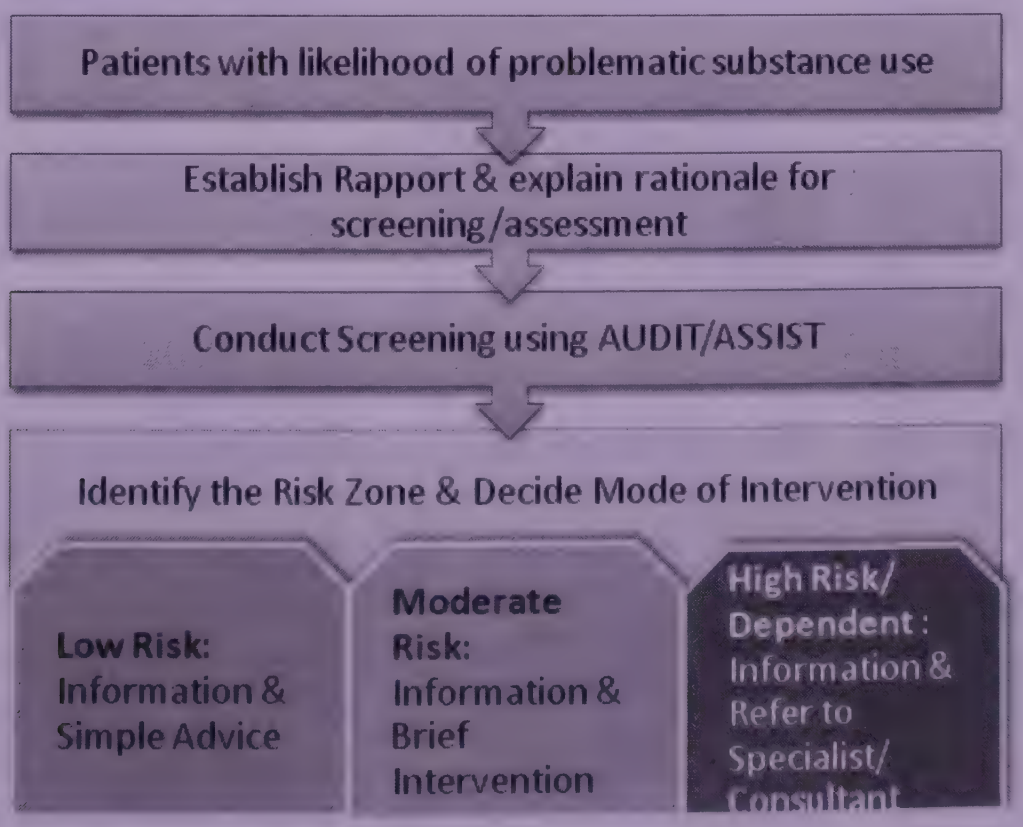


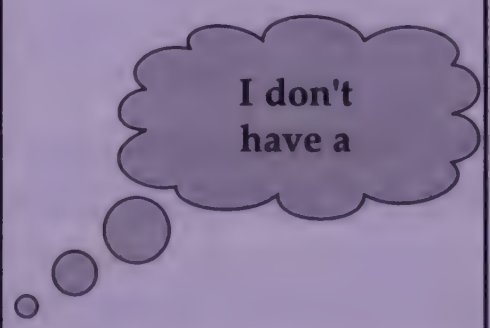
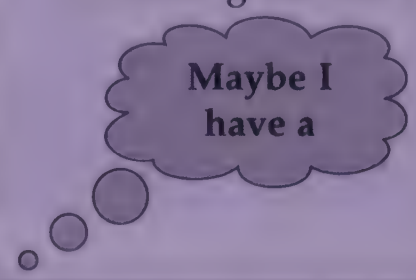
Figure 4: Screening and brief intervention process

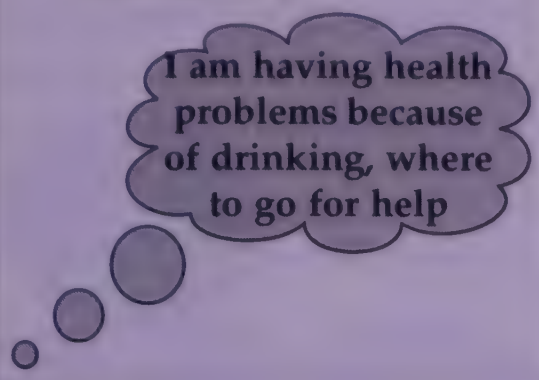
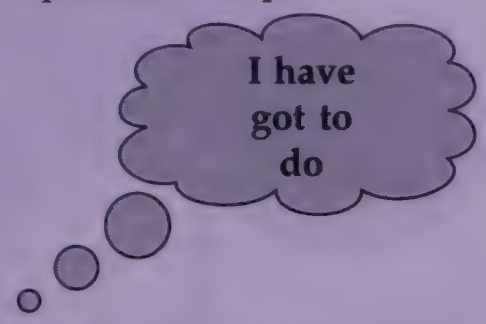
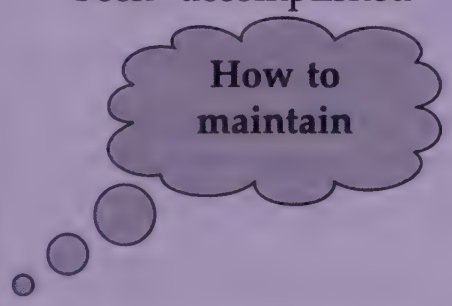
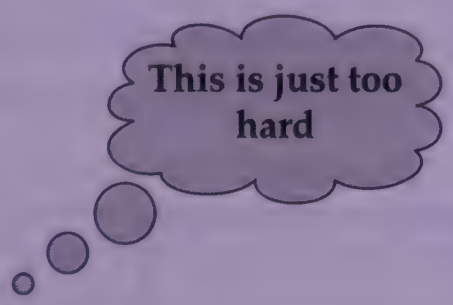
5

Model For Behavior Change And Motivational Interviewing

A model of behaviour change developed by Prochaska and DiClemente provides a useful framework for understanding the process by which people change their behavior, and for considering how ready they are to change their substance use or other lifestyle behaviour. The modal proposes that people go through discrete stages of change, and that the processes by which people change seem to be the same with or without treatment. The model as described in the table below includes several stages (Pre-contemplation, Contemplation, Preparation, Action, Maintenance, Relapse) a *brief* description of the underlying behavioral and cognitive processes of each stage and the strategy most likely to work for that patient.

Table 8: Stages of Change – Definition and treatment implications

Stage of Change	Definition	What will help
Pre-contemplation	No intent to change. More pros than cons to using 	Elicit patient's perception of substance use or any related problems Give factual information on potential risks Provide personalized feedback Examine the discrepancies Avoid confrontation Express concern and keep doors open
Contemplation	Thinking about the problem and delima about changing or remaining the same 	Facilitate the analysis of pros and cons. Help in realistic appraisal of the good and bad things about doing drugs/ substance.

Preparation	User begins to look at the sources of information for of sekeing help 	Discuss the range of possible strategies to achieve the patient's goals
Action	Actively modifying problem behaviors; learning skills to prevent relapse 	Help him/her lay a definite plan of action
Maintenance	Long-term strategies for maintaining the changes that have been accomplished 	Try to involve a significant other. Enable identification of Non chemical highs
Relapse	Return to an earlier stage 	Provide encouragement and new information based on their behaviors for managing subsequent attempts

It is also worth noting that there is no set amount of time that a person will spend in each stage (may be minutes to months to years), and that people cycle back and forth between stages. Some patients may move directly from pre-contemplation to action following brief intervention. The aim of the screening and brief intervention is to support people to move through one or more stages of change commencing with movement from pre-contemplation to contemplation

to preparation (also called determination) to action and maintenance. Movement from the stage of pre-contemplation to contemplation may not result in a tangible decrease in substance use, however is a positive step that may result in patients moving on to the action stage at some time in the future.

Enhancing Motivation

When enhancing motivation, using the appropriate strategy best suited for those patients renders it more effective. Some of the commonly used strategies are:

Figure 5 life domains for providing feedback

Presenting Personal Feedback: Motivational enhancement techniques usually focuses on giving a ***personalized*** feed back of the harms to the patient which have been caused by his substance use. It is important to use objective evidence such as biochemistry reports, or other reported health, familial, occupational, financial,or adverse legal consequences due to substance use. This is done to elicit self-motivational statements from the patient. While presenting feed back to the patient therapist responses to patient reaction to the discussion is crucial. It is important for the therapist to identify the concerns of the patient and talk about the concerns expressed by him and reinforce those concern to initiate change. Feed back is also useful in enabling the patient to see the relationship between the concerns expressed by him and substance use.

Decision balancing exercise: As mentioned earlier cognitive appraisal of cost and benefit of a particular behavior helps in making a decision for or against continuation of that. Decision balancing enables the patient to clarify and resolve ambivalence and in the process tilt the balance towards changing dysfunctional behavior. The decision balance strategy is designed to help the patient consider the positives (advantages) and negatives (disadvantages) of changing their current behaviors. When people consider making a change, it is helpful to think not only about the benefits (pros) of changing and the cost (cons) of staying the same, but also to reflect upon the possible consequences of changing and the potential benefits of staying the same. In MET the patient is usually persuaded to work through a decision balancing work sheet.

	Cost	**Benefits**
Using substanace		
Quiting substance		

Figure 6: Decision balancing worksheet

In decision balancing the patient is asked to fill in four specified boxes. In the first box, the patient is asked to write the cost of continuing the behavior (using psychoactive substance), while in the box below he or she writes the potential cost for changing. In the top-right box, the patients then identifies benefits of continuing with substance use while below let he writes the benefits of making the change (quitting substance use). This strategy offers the patient and therapist a more complete picture of the patient's ambivalence toward change. In the end the patient is enabled to analyse the cost of remaining the same vis a vis the cost of change with benefits of remaining the same and benefits of change and arrive at his own decision.

Other way of facilitating cost benefit analysis could be simple exercise in which the patient is asked to put benefits of staying the same and cost of change on one side of the scale and benefits of change and cost of staying the same on the other side of the scale. He than needs to decide on is own after seeing which ways the balance tilts.

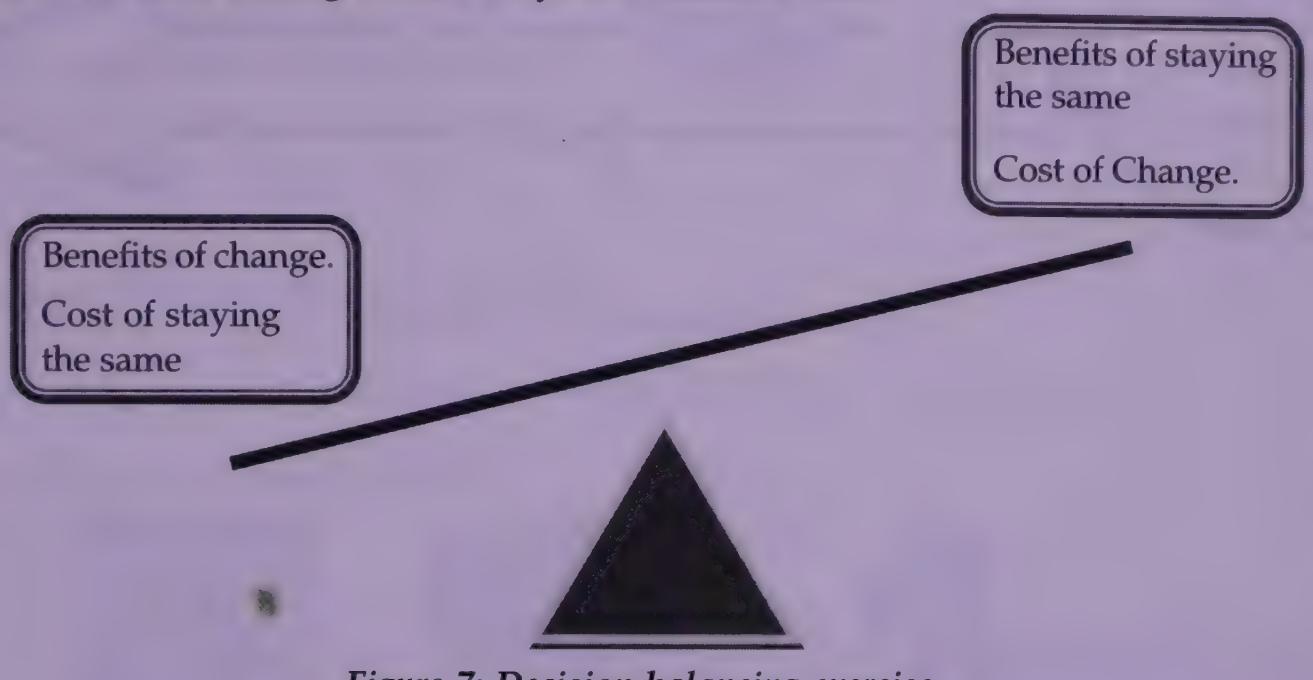


Figure 7: Decision balancing exercise

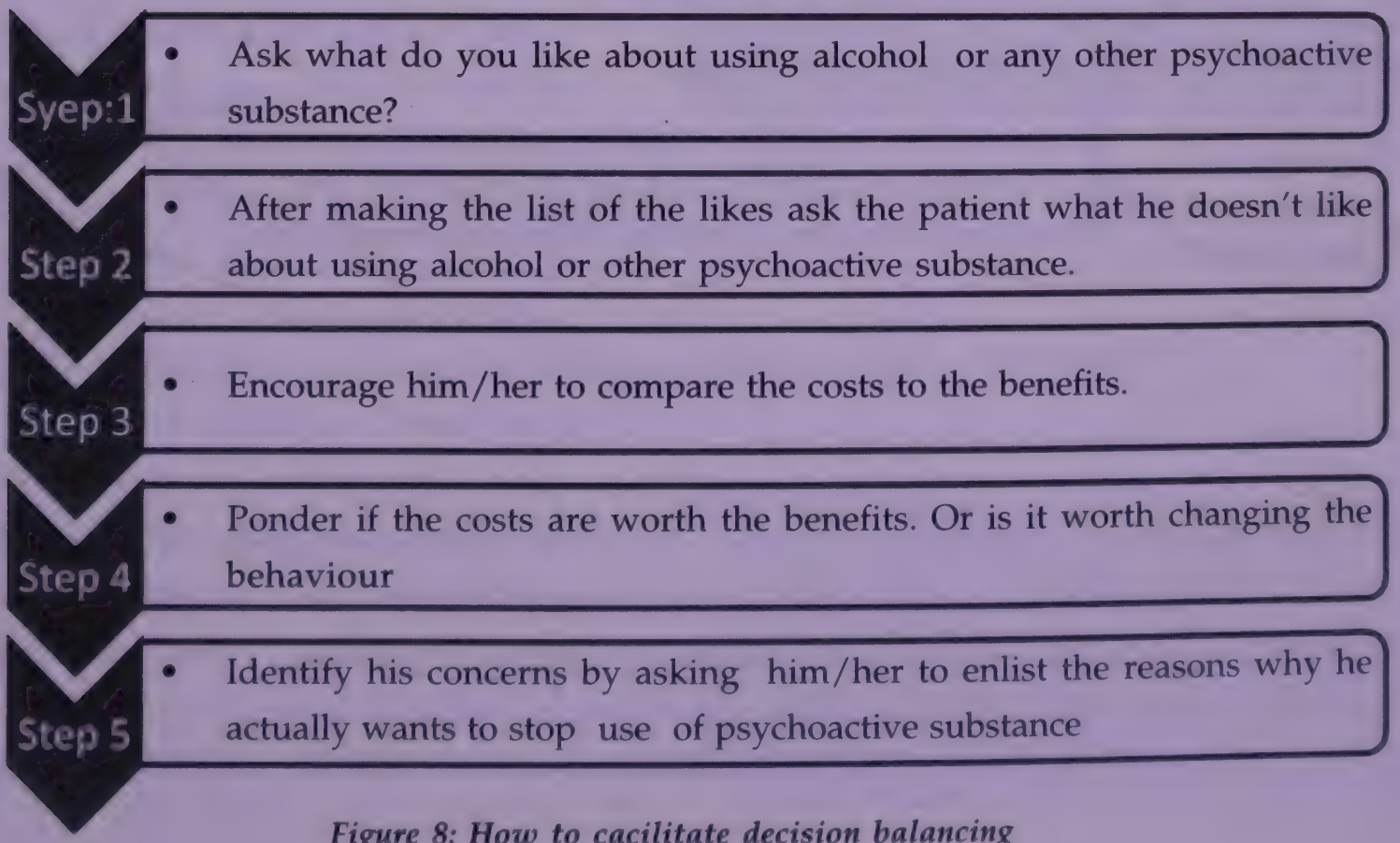


Figure 8: How to cacilitate decision balancing

Consequences of Inaction and Action: Another useful strategy is to ask the patient to anticipate what the result would be if he continued using as before. What would be the likely consequences? It may be useful to make a written list of the possible negative consequences of not changing. Similarly, the anticipated benefits of change can be generated by the patient.

How to enable the patient to make appraisal of the consequences of inaction and action:

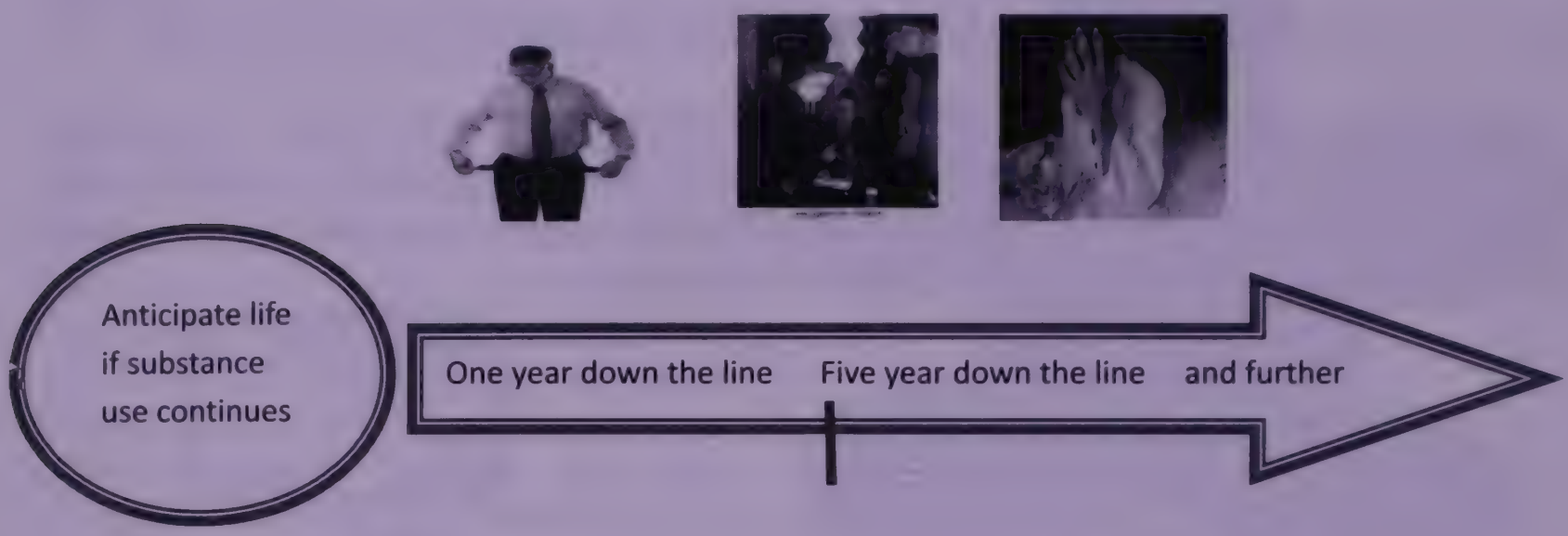


Figure 8: Consequences of Inaction

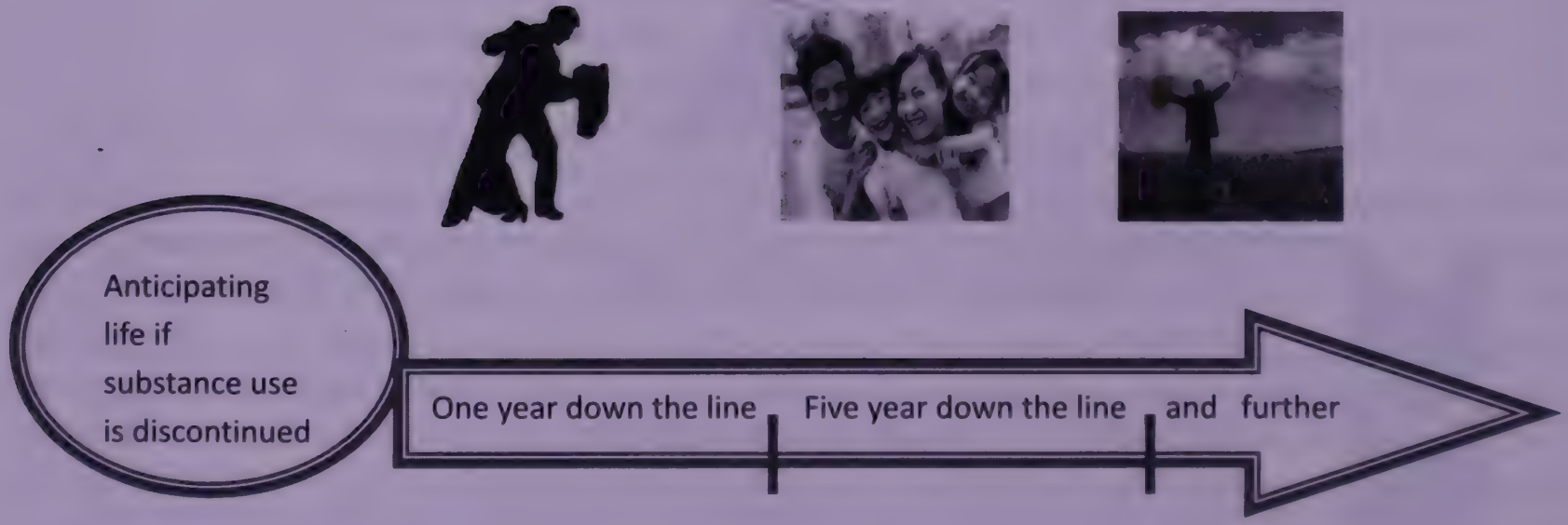


Figure 9: benefits of action

Developing discrepancy: Individuals decision to change the maladaptive behavior can be influenced by enabling them recognize a discrepancy or gap between their future goals and their current behavior. The therapist might clarify this discrepancy by asking, "Howdoes substance use fit in with having a family and a stable job?" When an individual sees that present actions conflict with important personal goals such as health, success, or family happiness, change is more likely to occur.

Supporting self efficacy: Realizing the importance of changing the problematic behavior and having a conviction in the need to change is just one aspect of readiness to change; the other crucial aspect of it is having the belief and confidence that the goal of changing the dysfunctional behavior is achievable. Many people despite having the understanding about the need to change do not attempt to do so, because they believe that the goal is too stiff for them to achieve. One of the crucial strategies in MET is to inculcate the Confidence in the patient that the goal is achievable and enabling him to believe that he has all the potentials and strengths to Change the undesired behaviour.

Motivational interviewing strategies

The basic principles of motivational interviewing include the following:

- **Expressing and listening with empathy**:
  It is an important strategy that Motivation Enhancement Therapy employs. It requires alert listening and a constant attempt to understand what your Patient actually means. Therapist also needs to pay attention to the nonverbal language of the Patient.

How to do it

Patient: *"My wife is always suspicious of me; she thinks I always use drugs."*

Empathy: *"I can understand your problem "*

- ***Affirmations:*** Therapist needs to affirm, reinforce and compliment the Patient. This enables, Developing of therapeutic relation ship.
  Enhancment in patients self efficacy and conficence in ability to change

How to do it

"Thanks for being patient in the session."
"I appreciate your strength in recognizing your problem and your initiative to do something about it."
"You really have some good ideas for how you might change your substance use .

- ***Eliciting motivational statements :*** It is important for Motivational enhancement counselor to elicit motivational statements

How to do it

This can be done by open ended questioning. You can use one of the following:
Therapist:"What brings you here; how can I help you?"
Patient :"I assume that since you have come here, that you are concerned about your substance use; can we talk about your concerns?"
Therapist:"How has your drug use changed over time? Tell me what you have noticed; has it been bothering you in any way?"

- ***Roll with resistance:*** Resistance to change is not dealt with head on, but the therapist moves on with it. The Patient is encouraged to think of the problem differently. He/she is never forced to make a decision.

How to do it

Patient : " I am not addicted to alcohol .
Therapist : So as far as you are concerned you have not had any problem with alcohol use.
Patient : " Well I cant say that exactly"
Therapist " So you think that alcohol is a problem but you don't want to be called an addict"

- ***Dealing with resistance:*** *When met with resistance* you need to keep in mind the following:
Never meet resistance head on. Never challenge or confront.
Remember your aim is to bring out self-motivational statements from the Patient.

- **Reflection** – Mirroring back the patient's feelings and verbalizations can help establish an effective therapeutic relationship with the patient and motivate him/her to think about change.Being non judgemental is the key here.
Repeat statements made by the patient and express similar emotions expressed by the patient as given in the adjoining box.

How to do it

Patient : My wife is always suspicious of me . She thinks I always do drugs
Judgment " She could be concerned about your health as she is your wife . Whats wrong with that?"
Reflection : " So your drug use has getting you into trouble with your wife . You seems to be annoyed with her being suspicious of you"

6

How To Conduct Brief Intervention

Brief Intervention

Brief interventions constitute a set of practices that identify real or potential drug and alcohol use problems and motivates the individual, who is at risk to change the hazardous or harmful use pattern. The Brief interventions usually take one to four sessions of 5-30 minutes duration and involve a combination of motivational interviewing and counseling techniques. The most widely used framework for conducting brief intervention has been provided by Miller and Sanchez . They have used acronym FRAMES to describe the structure of brief intervention

F	**Feedback**	Review of Personalised harms
R	**Responsibility**	Letting the responsibility of change lie with patient
A	**Advice**	Providing clear, practical, advice in favour of change and explaining what, why and how to change.
M	**Menu**	Providing variety of options and letting the patient choose the suited for him.
E	**Empathy**	Expressing warmth, concern and using reflective listing
S	**Self-efficacy**	Boosting patients confidence in his to ability change

Figure 11: **FRAMES structure of brief intervention**

To conduct brief intervention the current manual proposes the following four steps , which have to be used along with screening .

Initiating the session : It is important to keep in mind that the first step sets the tone for the successful brief intervention . Asking permission to discuss he subject formally lets the patient know that his or her wishes and perceptions are central in the intervention. So **raising the subject** forms the First step towards conducting the session

Conducting the session :

Objectives	Actions	Questions/Comments
Establish rapport	**Discuss your role**	• Hello. My name is Ramesh and I am here to discuss substance use related issues with you. • Ensure that you do this for all of your patients (so they don't feel)
Raise the subject	**Seek permission from the patient to discuss his problem.**	• Would it be okay to take a few minutes to talk about your substance use?" PAUSE to listen for and respect the answer.
Review information	**Avoid being judgmental Set the tone**	• "Has anyone ever talked with you about your substance use?" If yes, "When ? What were the results?" Include this information with the current screening results

Step two Provide feed back

Objectives	Actions	Questions/Comments
Review screening result	**Invoke patients interest in the screening result**	Would you like to see the screening result(if the patient do not show interest in knowing the score give him the risk card and copy of his screening score, keep the doorsopen and let him know that in case he wants to discuss it some other time he can come back.)
Show the screening result to the patient	**Express concern**	"From what I understand, you are using substance … (state the type and amount). We know that substance use at the level you are currently using can cause problems such as… (refer to present problems or to general increased risk of illness and injury in the future).I am Concerned about your substance use."
Review current substance use patterns and make connection between substance use, other health or other problems reported by the patient (if applicable),	**Reflect** **"So your drug use has been getting you into trouble with your wife. You seem to be annoyed with her being suspicious of you?"**	What connection (if any) do you see between your substance use and this visit? Discuss specific patient issues that might be related to substance use, e.g., road traffic accidents, hypertension, problem in the family, or work etc. If patient sees a connection, review what he or she has said. If patient does not see a connection, then make one, if possible, using facts, e.g., Road traffic accidents, family or work problem. Don't strain to draw connections if the visit is unrelated to their substance misuse.

Step Three: Enhance motivation

Objectives	Actions	Questions/Comments
Enable decision balancing	• **Ask the patients the cost of change and the cost of remaining the same.** • **Identify Concerns** • **Listen reflectively.** • **Ask open-ended questions**	• What in your perception are the benefits of using ———— (reported) Once the list is finished summarise e.g. you like the relaxation it provides you or you enjoy the company of your friends. Then Ask the patients • What cost are you paying for using the particular substance. (In terms of money, health, family and work life). • Enable cost benefit analysis
Develop discrepancy	• **Enable him to see what his life** • **goals are and how does substance use fit in achieving those?** • **Help patient see discrepancies or differences between his or her present behavior and concerns.** • **Listen reflectively.** • **Ask open-ended questions**	• What are the goals that you have set for yourself in life? • How do you want your life to be? • In what way does your help in leading the kind of life you wanted to
Discuss consequences of action and inaction	**Enable him to visualize life if the behavior is changed and compare it with the quality of life if the behavior is not changed**	• What changes do expect in life if the current behavior is Changed ? • And what if the behavior is not changed or modified?
Support self efficacy	Instill hope in the patient that change is possible.	• Many people have changed substance use behavior and you can do so, too.

Step four: Negotiate and Advice

Objectives	Actions	Questions/Comments
Negotiate goal and build self-efficacy (confidence in one's ability to change)	**Assist patient to identify a goal from a variety of options** **Avoid being argumentative**	"What are your options? Where do you want to go from here?" Ask about other times the patient has successfully made a change, e.g., quit smoking, and improved eating habits.
Give advice, with the patient's permission	• **Provide options for the patient to consider** • **Deliver sound advice/ education** • **Provide strategies to help reduce harm**	Options can include: cut back on how often I drink; cut back on how much I drink on days when I do drink; never drink and drive; a trial period of not drinking entirely; get help from someone with my drinking; do nothing.
Summarize	• **Help patient clarify goals to pursue** • **Provide handout**	• Thanks for being patient in the session." • It's nice to see that you have been able to sort out the reasons for the problem at your home or workplace. • "I appreciate your strength in recognizing your problem and your initiative to do something about it." • "You really have some good ideas for how you might change."

Appendix 1 : WHO - ASSIST V3.0

INTERVIEWER ID

PATIENT ID

INTRODUCTION (Please read to patient)

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Question 1

(if completing follow-up please cross check the Patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried

In your life, which of the following substances have you ever used? *(NON-MEDICAL USE ONLY)*	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:

If "No" to all items, stop interview.

"Not even when you were in school?"

If "Yes" to any of these items, ask Question 2 for each substance ever used.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

In the past three months, how often have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Monthly	Weekly	Daily Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify: codeine, etc.)	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the past three months, how often have youhad a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	`6

Question 4

During the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the past three months, how often have you failed do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)	Never	Once or Twice	Monthly	Weekly	Daily Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	.5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of of (FIRST DRUG, SECOND DRUG, ETC)	No. Never	Yes, in the past 3 Months	Yes, but not in the past 3 Months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

Question 7

Have you ever tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC)	No. Never	Yes, in the past 3 Months	Yes, but not in the past 3 Months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

Question 8

	No. Never	Yes, in the past 3 Months	Yes, but not in the past 3 Months
Have you ever used any drug by injection? (NON-MEDICAL USE ONLY)	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention

PATTERN OF INJECTING		INTERVENTION GUIDELINES
Once weekly or less Fewer than 3 days in a row	or	Brief Intervention including "risks associated with injecting" card
More than once per week 3 or more days in a row	or	Further assessment and more intensive treatment*

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: Q2c + Q3c + Q4c + Q5c + Q6c + Q7c

Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENTS SPECIFIC SUBSTANCE INVOLVEMENT SCORE

Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco	0 - 3	4 - 26	27+
b. alcohol	0 - 10	11 - 26	27+
c. cannabis	0 - 3	4 - 26	27+
d. cocaine	0 - 3	4 - 26	27+
e. amphetamine	0 - 3	4 - 26	27+
f. inhalants	0 - 3	4 - 26	27+
g. sedatives	0 - 3	4 - 26	27+
h. hallucinogens	0 - 3	4 - 26	27+
i. opioids	0 - 3	4 - 26	27+
j. other drugs	0 - 3	4 - 26	27+

NOTE

URTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available

Appendix - 2

AUDIT QUESTIONNAIRE

The following questions are about your substance use habits. Circle your answers.

Questions	0	1	2	3	4
1. How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are substance use?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or
4. How often during the last year have you found that you were not able to stop substance use once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of substance use?	Never	Less than	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy substance use session?	Never	Less than	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after substance use?	Never	Less than	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because you had been substance use?	Never	Less than	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured as a result of your substance use?	No		yes but not in the last year		Yes, during the last year
10. Has a relative or friend or doctor or other health worker been concerned about your substance use or suggested you cut down?	No		yes but not in the last year		Yes, during the last year

Scoring and Interpretation:

0-15: Low Risk, 16-19: Moderate Risk, 20-40: High Risk

INTERVIEWER ID

PATIENT ID

INTRODUCTION (Please read to patient)

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Question 1

(if completing follow-up please cross check the Patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you ever used? (NON-MEDICAL USE ONLY)	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:

If "No" to all items, stop interview.

"Not even when you were in school?"

If "Yes" to any of these items, ask Question 2 for each substance ever used.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

In the past three months, how often have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Monthly	Weekly	Daily Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the <u>past three months</u>, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the past three months, how often have you failed do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)	Never	Once or Twice	Monthly	Weekly	Daily Almost Daily
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of of (FIRST DRUG, SECOND DRUG, ETC)	No. Never	Yes, in the past 3 Months	Yes, but not in the past 3 Months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

Question 7

Have you ever tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC)	No. Never	Yes, in the past 3 Months	Yes, but not in the past 3 Months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

Question 8

	No. Never	Yes, in the past 3 Months	Yes, but not in the past 3 Months
Have you ever used any drug by injection? (NON-MEDICAL USE ONLY)	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention

PATTERN OF INJECTING		INTERVENTION GUIDELINES
Once weekly or less Fewer than 3 days in a row	or	Brief Intervention including "risks associated with injecting" card
More than once per week 3 or more days in a row	or	Further assessment and more intensive treatment*

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: Q2c + Q3c + Q4c + Q5c + Q6c + Q7c

Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENTS SPECIFIC SUBSTANCE INVOLVEMENT SCORE

Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco	0 - 3	4 - 26	27+
b. alcohol	0 - 10	11 - 26	27+
c. cannabis	0 - 3	4 - 26	27+
d. cocaine	0 - 3	4 - 26	27+
e. amphetamine	0 - 3	4 - 26	27+
f. inhalants	0 - 3	4 - 26	27+
g. sedatives	0 - 3	4 - 26	27+
h. hallucinogens	0 - 3	4 - 26	27+
i. opioids	0 - 3	4 - 26	27+
j. other drugs	0 - 3	4 - 26	27+

NOTE

URTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available

Appendix – 3

CAGE Questionnaire

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of ahangover (**E**ye opener)?

Scoring:

Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically signific

The CRAFFT Screening Questions

Please answer all questions honestly; your answers will be kept confidential.

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high?	☐	☐

"anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"

If you answered NO to ALL (A1, A2, A3) answer only B1 below, then STOP.

If you answered YES to ANY (A1 to A3), answer B1 to B6 below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

CONFIDENTIALITY NOTICE:
The information on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

Appendix – 5

The Drug Abuse Screening Test (DAST)

Patient's Name:		Date:	
Drug Abuse Screening Test—DAST-10			
These Questions Refer to the Past 12 Months			
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Guidelines for Interpretation of DAST-10 Interpretation (Each "Yes" response = 1)		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.
Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007;32:189-198.

Appendix 6

FAGERSTRÖM TEST FOR NICOTINE DEPENDENCE (ADULTS)

1. How soon after you wake up do you smoke your first cigarette? Score
- Within 5 minutes 3
- 6-30 minutes 2
- 31-60 minutes 1
- After 60 minutes 0

2. **Do you find it difficult to refrain from smoking in the places where it is forbidden (e.g., in church, at the library, in cinema)?**
- Yes 1
- No 0

3. **Which cigarette would you hate most to give up?**
- The first one in the morning 1
- Any other 0

4. **How many cigarettes/day do you smoke?**
- 10 or less 0
- 11-20 1
- 21-30 2
- 31 or more 3

5. **Do you smoke more frequently during the first hours after waking than during the rest of the day?**
- Yes 1
- No 0

6. **Do you smoke if you are so ill that you are in bed most of the day?**
- Yes 1
- No 0

Total Score:

Scoring:

0-2	Very low dependence
3-4	Low dependence
5	Medium dependence
6-7	High dependence
8-10	Very high dependence

Heatherton TF, Kozlowski LT, Frecker RC, FagerstrÖm K-O. The Fagerström Test for Nicotine Dependence: a revision of the Fagerström Tolerance Questionnaire. Br J Addict 1991;86:1119-1127.

Appendix – 7

Michigan Alcohol Screening Test (MAST)

This test is nationally recognized by alcoholism and drug dependence professionals. You may substitute the words "drug use" in place of "drinking".

1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)
Circle Answer: YES NO

2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?
Circle Answer: YES NO

3. Does any near relative or close friend ever worry or complain about your drinking?
Circle Answer: YES NO

4. Can you stop drinking without difficulty after one or two drinks?
Circle Answer: YES NO

5. Do you ever feel guilty about your drinking?
Circle Answer: YES NO

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
Circle Answer: YES NO

7. Have you ever gotten into physical fights when drinking?
Circle Answer: YES NO

8. Has drinking ever created problems between you and a near relative or close friend?
Circle Answer: YES NO

9. Has any family member or close friend gone to anyone for help about your drinking?
Circle Answer: YES NO

10. Have you ever lost friends because of your drinking?
Circle Answer: YES NO

11. Have you ever gotten into trouble at work because of drinking?
Circle Answer: YES NO

12. Have you ever lost a job because of drinking?
Circle Answer: YES NO

13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
Circle Answer: YES NO

14. Do you drink before noon fairly often?
Circle Answer: YES NO

15. Have you ever been told you have liver trouble such as cirrhosis?
Circle Answer: YES NO

16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?
Circle Answer: YES NO

17. Have you ever gone to anyone for help about your drinking?
Circle Answer: YES NO

Appendix – 8

READINESS TO CHANGE QUESTIONNAIRE [TREATMENT VERSION] REVISED EDITION 2007

The following questions are designed to identify how you personally feel about your drinking right now. Please think about your current situation and drinking habits, even if you have given up drinking completely. Read each question below carefully and then decide whether you agree or disagree with the statements. Please tick the answer of your choice to each question. If you have any problems please ask the questionnaire administrator.

Your answers are completely private and confidential

Key: SD = Strongly disagree D = Disagree U = Unsure
A = Agree SA = Strongly agree

	SD	D	U	A	SA	Office use
1 It's a waste of time thinking about my drinking because I do not have a problem.	•	•	•	•	•	PC
2 I enjoy my drinking but sometimes I drink too much.	•	•	•	•	•	C
3 There is nothing seriously wrong with my drinking.	•	•	•	•	•	PC
4 Sometimes I think I should quit or cut down on my drinking.	•	•	•	•	•	C
5 Anyone can talk about wanting to do something about their drinking, but I'm actually doing something about it.	•	•	•	•	•	A
6 I am a fairly normal drinker.	•	•	•	•	•	PC
7 My drinking is a problem sometimes.	•	•	•	•	•	C
8 I am actually changing my drinking habits right now (either cutting down or quitting).	•	•	•	•	•	A
9 I have started to carry out a plan to cut down or quit drinking.	•	•	•	•	•	A

10 There is nothing I really need to change about my drinking.	•	•	•	•	•	PC
11 Sometimes I wonder if my drinking is out of control.	•	•	•	•	•	C
12 I am actively working on my drinking problem	•	•	•	•	•	A

FOR OFFICE USE ONLY

Please enter the subject's scores below:

Scale Scores

PC Score ☐

C Score ☐

A Score ☐

Source: Heather N, Hönekopp J. A revised edition of the Readiness to Change Questionnaire [Treatment Version] 2008; 16: 421-33

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Manual for Primary Health Care Workers.....

Provides useful information about concepts and terminologies of drug use, process of screening for drug use and providing brief intervention to patients at risk. It offers strategies to motivate patients to change their risky drug use patterns and offers a step by step approach to deliver brief intervention to harmful or hazardous substance users.

Also find information sheet for educating patients about potential harms associated with drug use and useful tools to screen for alcohol and substance use inside!

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